

No. 2  
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-17-39  
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FILED JAN 21 1945 89

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 5702

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Livingston  
(b) City or town Mooreville Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Rural Mooreville, Mo  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
in this community A years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Livingston  
(c) City or town Mooreville, Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. Mooreville  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Robert Henry Gilliland

3. (b) If veteran, name war No. 3. (c) Social Security No. No.

4. Sex MALE 5. Color or Race White 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased March 31 1867  
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 14 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Illinois (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name William T. Gilliland

13. Birthplace Ill. (City, town, or county) (State or foreign country)

14. Maiden name Harding

15. Birthplace Ill. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R.H. Gilliland

(b) Address Mooreville Mo.

17. (a) Burial (b) Date thereof Jan 17 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Montreal

18. (a) Signature of funeral director E.A. Dickerson

(b) Address Boyard Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 17 year 1945 hour 8 PM minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Jan 1 1945 to Jan 17 1945  
that I last saw him alive on Jan 15 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Statis Pneumonia 2 days  
Due to flu Duration 8 wks  
Due to 330  
Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature P. G. Moore (M. D. or other) \_\_\_\_\_  
Address Boyard Mo. Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

*please forward to  
correct registration*

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Ed. DeKernan*

Licensed Embalmer No.....

*2534*

P. O. Address.....

*Bogard m*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 189

Primary Registration District No. 5702

1944 FEB

1944

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County Livingston  
(b) City or town Mooresville, rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Mooresville Hosp.  
(If not in hospital or institution, write street number & location) Rural  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert H. Gilliland

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 3, 1868  
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 17 (If less than one day, min.)

9. Birthplace Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Mrs. T. Gilliland

13. Birthplace Ill.  
(City, town, or county) (State or foreign country)

14. Maiden name Haiding

15. Birthplace Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R.H. Gilliland

(b) Address Mooresville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Monroe

18. (a) Signature of funeral director E. G. Dickerson

(b) Address Boyard Mo.

19. (a) Jan 26 1944 (Date received local registrar) (b) Goala Romberger (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Livingston  
(c) City or town Mooresville Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 27 Year 1944 Hour 7:45 Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Jan 17 1944 to Jan 17 1944 that I last saw him alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death: Static pneumonia  
Due to flu  
Duration 2 day

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Geo. Moore (M. D. or other) Address Judlow, Mo. Date signed \_\_\_\_\_

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